TRENDS

Health Benefits In 2005: Premium Increases Slow Down, Coverage Continues To Erode

The average cost of family coverage now exceeds the average yearly income of minimum-wage Americans.

by Jon Gabel, Gary Claxton, Isadora Gil, Jeremy Pickreign, Heidi Whitmore, Benjamin Finder, Samantha Hawkins, and Diane Rowland

ABSTRACT: This paper reports findings on the state of job-based health insurance in spring 2005 and how it has changed during recent years. Premiums rose 9.2 percent, the first year of single-digit increases since 2000. The percentage of firms offering health benefits has fallen from 69 percent in 2000 to 60 percent in 2005. Cost sharing did not grow appreciably in the past year. Enrollment in preferred provider organizations (PPOs) grew from 55 percent in 2004 to 61 percent in 2005, while enrollment in health maintenance organizations (HMOs) fell from 25 percent to 21 percent of the total.

COVERING 159 MILLION Americans under age sixty-five and supplementing Medicare coverage for fifteen million elderly people, employer-sponsored health insurance remains the nation's leading form of insurance coverage.[1] This paper reports findings from the seventh annual Henry J. Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) survey of employer health benefits.

Study Data And Methods

Core elements of the questionnaire used in the Kaiser/HRET survey are identical to questions asked in previous surveys conducted by the Health Insurance Association of America (HIAA) from 1987 to 1991 and KPMG Peat Marwick from 1991 to 1998. Thus, for several key questions, there are nineteen years of data available for making statistical estimates and comparisons. These core elements include data on the firm's largest conventional, health maintenance organization (HMO), preferred provider organization (PPO), and point-of-service (POS) plans. The survey also asks employees' plan participation and employers' attitudes about health benefits.

Kaiser/HRET draws its sample from a Dun and Bradstreet listing of U.S. firms. Employers range in size from three to hundreds of thousands of workers and include public and private firms. The sample is stratified by size and industry. In 2005 the overall response rate was 48 percent, which includes firms that offer and

Jon Gabel (jgabel@hschange.org) is a vice president of the Center for Studying Health System Change (HSC) in Washington, D.C. Gary Claxton is a vice president of the Henry J. Kaiser Family Foundation (KFF) in Washington; Isadora Gil is a policy analyst there. Jeremy Pickreign is a researcher at HSC, based in Rensselaer, New York. Heidi Whitmore is a researcher at HSC in Washington. Benjamin Finder is a research assistant at KFF. Samantha Hawkins is research manager at the Health Research and Educational Trust (HRET) in Washington. Diane Rowland is executive vice president of KFF. Gabel, Pickreign, and Whitmore were employees of HRET when this research was conducted.

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do not offer health benefits. Among firms that offer health benefits, the response rate was 51 percent.

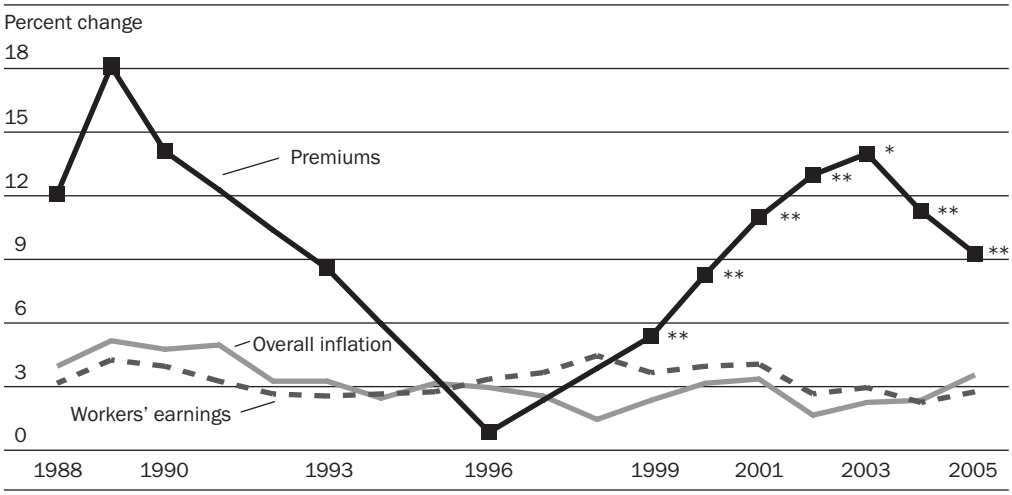
Using computer-assisted telephone interviews, National Research LLC surveyed employee benefit managers from January to May 2005. In 2005, 2,013 firms completed the entire survey; 56 percent of them also participated in the survey in either 2003 or 2004 or both. Prior surveys indicate that firms not offering benefits are less inclined to participate in the survey. Therefore, we asked firms that declined to participate in the full survey one question: "Does your company offer or contribute to a health insurance program as a benefit to your employees?" A total of 982 additional firms answered this question. The response rate for this one question was 72 percent.

Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm-size estimates using statistical weights. Data are identified in the text and exhibits as representing either the percentage of firms, workers, or insured workers. In calculating weights, we first determined the basic weight, then we applied a nonresponse adjustment, and finally we applied a post-stratification adjustment. We used the statistics of the U.S. Census Bureau as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we used the Census of U.S. Governments as the basis for the post-stratification adjustment for public-sector firms.[2] All differences discussed in the text are significant at the .05 level unless otherwise noted. Standard errors are calculated using the statistical software package SUDAAN, which adjusts for the complex design of the survey.

Findings

■ **Cost of coverage.** *Premium increases.* Premiums rose 9.2 percent from spring 2004 to spring 2005 (Exhibit 1). This was the first year of single-digit increases since 2000 and the second consecutive year when premiums rose less than they did the previous year.[3] Premium increases outpaced overall inflation by nearly

EXHIBIT 1
Increases In Employer Health Insurance Premiums Compared With Other Indicators, Selected Years 1988–2005



SOURCES: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; Health Insurance Association of America, 1988–1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, April to April), 1988–2005; and Bureau of Labor Statistics, seasonally adjusted data from the Current Employer Statistics Survey, 1988–2005.
NOTES: Data on premium increases reflect the cost of health insurance premiums for a family of four. Statistical significance indicators denote that premium estimates are statistically different from the previous year shown.
*$p < .10$ **$p < .05$

six percentage points and increases in workers' wages by more than six percentage points.[4] Premiums have risen 73 percent since 2000.

Premium increases varied little by plan type, and there was no significant difference between the rate of increase in fully insured and self-funded plans. With premium increases averaging 12.4 percent, the manufacturing sector, which experienced a net loss of jobs during the past year, experienced larger increases than other industries.[5]

The average monthly cost for single and family coverage, including employer and employee contributions, is $335 and $907, respectively (Exhibit 2). Single coverage costs $4,024 and family coverage costs $10,880 for a year. Thus, the average cost of family coverage now exceeds annual earnings for a minimum-wage earner who is employed throughout the year. Differences in cost of coverage across firm sizes are not statistically significant. PPOs—the plan type with the most enrollment—have significantly higher premiums than HMOs for both single and family coverage.

Employee contributions and cost sharing. On average, employees contribute $51 per month for single coverage and $226 for family coverage, statistically unchanged from last year (Exhibit 3). Ten percent of covered employees work for a firm that varies employees' monthly contributions by their earnings. Large firms (200 or more workers) are more likely than small firms (3–199 workers) to do this. Three percent of employees work for a firm that adjusts employees' monthly contributions for premiums based on the employee's participation in the company's wellness program.

EXHIBIT 2
Monthly Premiums And Employee Contribution Levels For Single And Family Coverage, 2005

	Premium ($)		Employee contribution ($)	
Category	**Single**	**Family**	**Single**	**Family**
All plans	335	907	51	226
Plan type				
Conventional	315	832	41	193
HMO	314**	871**	47	217
PPO	346**	924	50	220
POS	326	900	61	271**
Region				
Northeast	346	959**	57	188**
Midwest	342	926	54	201**
South	329	876**	55	274**
West	328	886	35**	210
Firm size (workers)				
3–24	346	871	50	248
25–49	340	911	44	279**
50–199	325	878	44	271**
200–999	342	915	49	239
1,000–4,999	344	933	57**	216
5,000 or more	329	915	53	191**

SOURCE: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 2005.

NOTES: Statistical significance denotes difference from "all plans." HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan.

**$p < .05$

EXHIBIT 3
Average Monthly Contribution, Percentage Of Premiums Paid By Covered Workers For Single And Family Coverage, And Average Deductible By Plan Type, Selected Years 1988–2005

	1988	1993	1996	2000	2001	2002	2003	2004	2005
Monthly worker contribution									
Single	$ 8	$ 34	$ 37	$ 28**	$ 30	$ 39**	$ 42	$ 47	$ 51
Family	52	124	122	135	149**	178**	201**	222**	226
Percent of premiums paid by worker									
Single	11%	20%	20%	14%**	14%	16%	16%	16%	16%
Family	29	32	27	26	26	28	27	28	26
Deductibles (in-network)									
Conventional, individual	$163	$222	$264	$248	$239	$295	$384	$414	$602
HMO, individual	–[a]	–[a]	–[a]	–[a]	–[a]	–[a]	30	44	71
PPO, individual	106	170	180	175	204**	251**	275	287	323
POS, individual	–[b]	–[b]	71	70	92	54**	113**	210	220

SOURCES: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 2000–2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; and Health Insurance Association of America (HIAA), 1988.

NOTES: Plans with lower enrollment, such as point-of-service (POS) and conventional plans, have large variation in their estimates, which means that large differences may not be significantly different. Statistical significance denotes difference from previous year shown. HMO is health maintenance organization. PPO is preferred provider organization.

[a] Data were not collected for HMO plans from 1998 to 2002.

[b] Data were not collected for POS plans in 1988 and 1993.

$^{**}p < .05$

For the second consecutive year we found that out-of-pocket costs for deductibles and copayments did not increase at a statistically significant rate for most employees in 2005. For PPOs, the average single-coverage deductible for in-network services is $323 (statistically unchanged from 2004). Point estimates for office-visit cost sharing across all plans continue to drift upward, but year-to-year differences are not significant.

In looking at cost sharing, focusing on the average can obscure the variation in workers' potential out-of-pocket costs. In PPOs, for example, there is a sizable range around the $323 average in-network deductible for single coverage: 29 percent of covered workers are in plans with zero deductible, while 9 percent are in plans with a deductible of more than $1,000. Consistent with previous years, we also see differences across firm sizes, where small firms have an average annual in-network PPO deductible for single coverage of $469, compared with $254 in large firms. If we exclude workers who face no deductible from the average, the average deductible amounts rise to $639 for workers in small firms and $364 for workers in large firms.

Although deductibles have risen in recent years, an appreciable amount of spending is "carved out" from the deductible. In copayment plans, physician visits are usually not subject to deductibles. Additionally, 63 percent of insured workers belong to a plan in which designated preventive benefits are carved out from the deductible.

Although more routine services are often not subject to deductibles, employees face greater cost sharing when hospitalized than in the 1990s. Half of covered workers are subject to either hospital-specific deductibles or copayments (although there was no statistical change from 2004). One-third face a separate deductible for each admission, with an average hospital deductible of $241.

Prescription drug expenses. Virtually all covered employees continue to receive coverage for prescription drugs; almost 90 percent are in drug plans with multi-tier cost-sharing formulas. About three-quarters of workers with drug coverage face three- or four-tier cost-

sharing formulas, where the patient's copayment or coinsurance is dependent on the cost or type of drug prescribed and the availability of cheaper generic or brand-name options. Another 15 percent of such workers have two-tier benefits.

Most employees in plans with tiered drug benefits face copayments rather than coinsurance for generic, preferred, and nonpreferred drugs. Coinsurance is more prevalent than copayments for fourth-tier drugs (typically lifestyle or specialty drugs), but only 4 percent of employees with drug coverage are in four-tier plans. Ten percent of workers with drug coverage face a separate drug deductible.

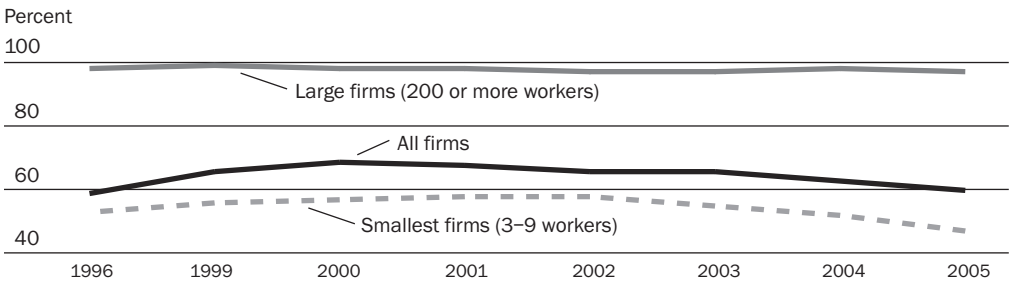
In most cases, changes to the copayment levels in multi-tier drug plans were modest in 2005: The average copayment for a generic drug is $10; for a preferred drug, $22; for a nonpreferred drug, $35; and for a fourth-tier drug, $74.[6] For workers who face coinsurance for fourth-tier drugs, the average coinsurance level is 43 percent.

■ **Availability of coverage.** Although premium increases appear to be stabilizing, the availability of employer coverage continues its downward trend (Exhibit 4).[7] The offer rate for the smallest employers (3–9 workers) is 47 percent in 2005, compared with 52 percent in 2004 and down from 57 percent in 2000.[8] The offer rate among large employers (200 or more workers) remains high (98 percent). Just 43 percent of firms with at least 35 percent of workers earning $20,000 or less offer health benefits to their workers, compared with 65 percent of firms with fewer low-wage workers.

Small firms (3–199 workers) not offering coverage are most likely to say that cost and the firm's size are "very important" reasons for not offering benefits.[9] Three-fourths of small firms report that high premiums were very important in their decision, and half cite small firm size as very important. Other factors affecting small firms' decision not to offer coverage include employees are covered elsewhere (33 percent), the ability to attract and retain good workers without offering coverage (22 percent), high turnover (16 percent), and administrative hassle (14 percent). Almost a quarter of nonoffering small firms report that they offered health benefits within the past five years—about the same percentage seen in previous years. Two-fifths of non-offering small firms shopped for health insurance in the past year but did not take it up.

We asked nonoffering firms about their workers' preferences for higher wages or health insurance. We asked them to assume that they could pay their employees an additional $2 per hour, and then asked them whether they believed that their employees would prefer to receive the additional compensation in the form of higher wages or health insurance. Seventy-one percent of firms said that in their view, workers would prefer higher

EXHIBIT 4
Percentage Of Firms Offering Health Benefits, By Firm Size, Selected Years 1996–2005



SOURCES: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2005; and KPMG Survey of Employer-Sponsored Health Benefits, 1996.

wages, which suggests that these firms would be unlikely to offer benefits even if they could afford to raise employee compensation.

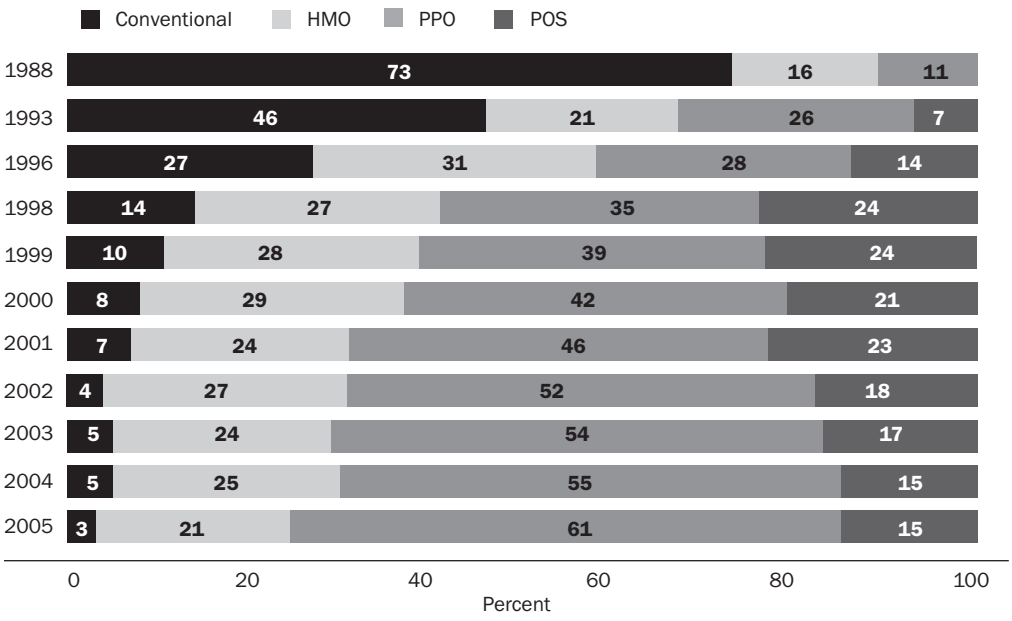
Nonoffering firms also were asked how much they and their employees could afford to contribute if they were to offer health insurance. On average, such firms said that they could afford to contribute about $161 per month and that their employees could afford $113. We note that this is about 80 percent of the premium cost for single coverage.

■ **Plan enrollment.** PPO enrollment grew and HMO and conventional enrollment fell during the past year (Exhibit 5). PPOs now enroll 61 percent of workers with job-based coverage, up from 55 percent in 2004. HMO enrollment fell from 25 percent to 21 percent. POS enrollment remained steady at 15 percent.[10] Nonetheless, enrollment growth during the past year continues a long-term trend. Since 1998, PPOs' share has risen from 35 percent to 61 percent of enrollment, while HMOs' share has declined from 27 percent to 21 percent.

■ **High-deductible plans.** Elsewhere we report on high-deductible plans that are offered with a health reimbursement arrangement (HRA) or are health savings account (HSA) qualified plans.[11] We find that 4 percent of employers offer one of these arrangements in 2005, covering about 2.4 million insured workers. Average single-coverage deductibles in these arrangements are around $1,900, and employers' contributions to the accounts for single coverage average $792 for HRAs and $553 for HSAs.

■ **Utilization and disease management.** The health insurance industry turned away from prospective utilization management (UM) in the late 1990s. Based on site visits to twelve communities, Glen Mays and his colleagues reported that health plans were returning to UM in 2002 and 2003, with a growing emphasis on disease and high-cost case

EXHIBIT 5
Health Plan Enrollment Among Covered Workers, By Type Of Plan, Selected Years 1988–2005



SOURCES: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2005; and KPMG Survey of Employer-Sponsored Health Benefits, 1988, 1993, and 1996.
NOTES: For 1998–2003 and 2005, the distribution is significantly different from the previous year shown, at the .05 level. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan.

management.[12]

The 2005 Kaiser/HRET survey asked employers for the first time since 1997 about the use of three UM techniques: preadmission certification for inpatient hospitalization, precertification for outpatient surgery, and case management for large claims.[13] Four-fifths of covered workers in large firms (200 or more workers) are enrolled in a plan that uses preadmission review for inpatient hospitalization in 2005, compared with 92 percent in 1997; 52 percent are in a plan using preadmission review for ambulatory surgery in 2005—identical to the finding in 1997; and 91 percent are in a plan using high-cost case management in 2005, compared with 81 percent in 1997.

"A key question for the future is whether employers and health plans can find effective ways to address the growing affordability problem."

During the past three years the Kaiser/HRET survey has consistently reported that employers—particularly those with 5,000 or more workers—are more optimistic about disease management programs' (DMPs') ability to control health care costs than other strategies, such as tighter managed care or consumer-driven health care. In 2005, 56 percent of workers with job-based insurance are enrolled in a health plan with a DMP. Among large firms (200 or more workers), this figure is 67 percent. Since many health plans include DMPs as standard components of their health plan, some small employers may be unaware of this because the employer plays no role in its administration. Hence, our finding that 56 percent of covered workers are in a plan with a DMP is likely a lower bound.

The most common DMP is for diabetes, available to 99 percent of covered workers in a plan with such a program. Asthma programs are available to 86 percent of covered workers in such plans; hypertension programs, to 82 percent; and high-cholesterol programs, to 66 percent. HMOs are more likely than other plan types to offer DMPs. Many of these programs have been frustrated by low enrollment for people with chronic conditions. Yet among covered workers in plans with disease management, only 7 percent work for a firm where the employer provides financial incentives to participate in the DMP.

■ **Wellness programs.** To make employees more responsible for their medical care and health, and in reaction to the "obesity epidemic," some employers have invested in wellness programs. The Kaiser/HRET survey shows a sharp divide between small employers (3–199 workers) and jumbo firms (5,000 or more). Among firms both offering and not offering health benefits, 44 percent of jumbo firms provide on-site fitness or health facilities, compared with 8 percent of small firms. Similarly, 4 percent of small firms and 43 percent of jumbo firms offer smoking cessation programs; 16 percent of small firms and 41 percent of jumbo firms offer injury prevention programs; and 4 percent of small firms and 42 percent of jumbo firms offer weight-loss programs.

■ **Employers' attitudes and views for the future.** Each year we ask employers for their views of the effectiveness of different forms of cost containment. Among firms both offering and not offering health benefits, few believe that any of the suggested approaches is likely to be "very effective" at controlling health care costs (16 percent for consumer-driven health plans, 14 percent for DMPs, 12 percent for higher employee cost sharing, and 7 percent for tightly managed care networks). A fairly large percentage of employers (37–46 percent) continue to believe that each of these approaches is "somewhat effective" in controlling costs. Twenty-three percent of large employers view disease management as "very effective," compared with 14 percent of small employers.

Large employers remain more likely than small employers to say that they plan on increasing employees' costs next year. More than 40 percent of large employers say that they are "very likely" to increase employee contribu-

tions, compared with 15 percent of small employers. Large firms also are about twice as likely as small firms to say that they are "very likely" to increase employee cost sharing for deductibles and prescription drugs, although the proportion of large firms saying this is relatively low (12–16 percent). Relatively few employers have decided to introduce new consumer-directed health plans in the next year, although interest is higher among the largest firms.[14]

Outlook For The Future

The falling rates of premium increases that we have seen over the past two years is good news for employers and employees struggling to maintain health benefits. However, even at these lower levels, premium increases are outpacing the general price increases and growth in the economy. Health insurance is becoming less affordable for many every year, which may explain the steady erosion in recent years in the percentage of firms offering health benefits.

A key question for the future is whether employers and health plans can find effective ways to address this growing affordability problem. A large percentage of employers have implemented disease management, case management, and wellness programs to address cost growth, and a small but growing percentage have adopted new health plan designs intended to reduce premium growth through consumerism. However, there is little evidence to suggest that any of the strategies being deployed by plans and employers can bring premium trends close to the rate of economic growth. If current strategies—from disease management to consumerism—are unsuccessful, coverage will continue its slow but long-term decline.

NOTES

1. P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey," Issue Brief no. 276 (Washington: Employee Benefit Research Institute, December 2004).
2. In 2005 we updated our data to reflect the 2002 Census of Governments. In the process, we chose to remove federal employee counts from our post-stratification. Although this change had no effect on the number of government firms, it reduced the number of government workers in the weights by approximately seven million.
3. Premium increase figures are based on answers to two questions: "How do the total costs for family coverage compare with what they were one year ago?" and "What percentage did costs for family coverage increase (decrease) since last year?" There are no adjustments in the premium-increase figures for benefit changes.
4. The Consumer Price Index (CPI) rose 3.5 percent, and workers' hourly wages increased 2.7 percent for this same period of time, according to the U.S. Bureau of Labor Statistics.
5. See Bureau of Labor Statistics, "Table 4: Employment Change from Same Month a Year Ago, in Thousands, Seasonally Adjusted," ftp.bls.gov/pub/suppl/empsit.tab4.txt (5 July 2005).
6. The change between 2004 and 2005 in the copayment for generic drugs is not statistically significant at the .05 level. Copayment changes for preferred, nonpreferred, and fourth-tier drugs were significant ($p < .05$).
7. The change in offer rate from 2004 to 2005 is not statistically different, but it is significantly different from 2000 to 2005 ($p < .05$).
8. The change in offer rate for firms with three to nine employees is not statistically different between 2004 and 2005, but it is significantly different from 2002 to 2005 ($p < .05$).
9. We do not report on larger nonoffering firms because we have a very small number in our sample.
10. A portion of this change is likely attributable to incorporating more recent census estimates of the number of state and local workers and removing federal workers from the weights.
11. G. Claxton et al., "What High-Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs*, 14 September 2005, content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.434.
12. G. Mays, G. Claxton, and J. White, "Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies," *Health Affairs*, 11 August 2004, content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.427 (5 July 2005).
13. In 1997, KPMG Peat Marwick conducted the survey and limited the survey to firms with 200 or more workers.
14. See Claxton et al., "What High-Deductible Plans Look Like."